



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

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Mark D. Birdwhistell
Secretary

Shawn M. Crouch
Commissioner

September 10, 2007

**TO: Nursing Facility (12) Providers
Provider Letter A-230**

RE: MMIS Prior Authorization Process

Dear *KyHealth Choices* Provider:

KyHealth Choices implemented a new Medicaid Management Information System (MMIS) effective June 4, 2007. The new MMIS provides significant changes for the Nursing Facility **prior authorization process**. Listed below are some changes providers will encounter with the implementation of the prior authorization process.

Confirmation Notices

- With the rollout of the new MMIS system, EDS discontinued the issuance of the traditional "confirmation notice". Instead, providers were receiving letters for Medicaid eligible residents only with prior authorization information.
- To assist in the application process, EDS will resume the issuance of "confirmation notices" for all reviewed residents, both Medicaid pending and Medicaid eligible, to provide written documentation for all level of care determination requests. However these confirmation notices, will no longer contain a certification number.

(Please see reverse side)



KyHealth Choices Provider

September 10, 2007

Page two

- With the new MMIS system, a prior authorization number can only be issued to a resident with a Medicaid assigned member ID number. The prior authorization letter will be issued once the resident becomes Medicaid eligible and receives a Medicaid assigned member ID number.

Prior Authorization Number

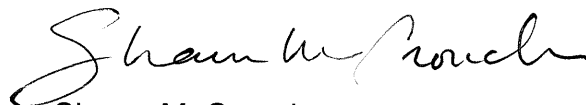
- For a pending Medicaid eligible member, providers will be sent a confirmation notice immediately, but will **not** receive a prior authorization letter with a prior authorization number to be used for billing until the member becomes Medicaid eligible. The new MMIS cannot issue a prior authorization to a resident until he/she has received a Medicaid assigned member ID number.
- If a resident is Medicaid eligible and has a Medicaid assigned member ID number, you will receive a "confirmation notice" of the medical review for level of care determination and a prior authorization letter that will contain the prior authorization number needed when billing a claim. These letters should arrive around the same time.

Reference Number

- When providers fax level of care requests (MAP-726A) for medical review, a form will be returned with the "reference number" listed. This "reference number" can be used to assist in the Medicaid application process, but is not a valid number for billing. Only the prior authorization number may be utilized in billing a claim.

If you have any questions or require any additional information, please contact Ms. Angela G. Kirkland, Director of Long Term Care and Community Alternatives, at (502) 564-7540, Monday through Friday, 8:00 a.m. until 4:30 p.m. (eastern-time).

Sincerely,



Shawn M. Crouch
Commissioner

Xc: Nursing Facility (12) Provider Letter A-230

SMC/CB/amd00325